MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address RS Medical PO Box 872650 Vancouver WA 98687-2650	MDR Tracking No.: M4-03-7262-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Liberty Mutual Fire Ins. 2875 Browns Bridge Rd. Gainesville GA 30504	Date of Injury: Employer's Name: Autozone, Inc. Insurance Carrier's No.: 949618245

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/10/03	**3/9/03**	**E1399**	**$250.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

5/27/03: "Statement of Disputed Issue – Rental of RS4I Sequential Stimulator…a combination 4 channel…device…Payment has been denied "A" stating charges will exceed $500.00…and therefore required preauthorization…monthly rental charge…does not exceed $500.00"

PART IV: RESPONDENT'S POSITION SUMMARY

7/23/03: "We base our payments on the Texas Fee guidelines and the TWCC Acts and Rules… A different provider (Stat 2000) had been billing for stimulator rental (BMR NT 200 stimulator) for this claimant and continues to bill for a unit for the month of February and March of 2003. Bills and EOB's for stimulator rental on this claim are attached. Rental was paid for March, April, May, June and July of 2002. Additional rental was preauthorized for a trial period of two months and we were billed for October, November, December 2002 and January and February of 2003. On 12/5/02, the purchase of the stimulator was denied by preauthorization. RS Medical then began billing for their stimulator 1/10/03 and continued through February 2003. These charges were denied because further rental was not preauthorized and purchase had already been denied. The provider contends that the $500 requirement for preauthorization had not been reached but it had, in fact, been reached many months before…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code E1399 (RS4I) for DOS 2/10/03 – 3/9/03 was first denied; 'Z – Pre-Authorization was requested but denied for this service per TWCC Rule 134.600.' The subsequent denial was 'A – pre-authorization was required, but not requested for this service per the TWCC Rule 134.600.'

- The respondent submitted convincing evidence that the R541 rental had exceeded the $500 limit per rule 134.600(h)(11), and according to 134.600 (i)(5) and (j) preauthorization was sought, and not received. Reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Carol Lawrence	03/29/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____